South Dakota Board of Nursing
Unlicensed Assistive Personnel
4305 South Louise Avenue Suite 201
Sioux Falls SD 57106-3115
(605) 362-2760 Fax: (605) 362-2768

Certified Nurse Aide (CNA) Renewal Application

***Allow up to 5-7 business days** for the SDBON to process your application**

To renew registration, the Nurse Aide shall submit verification of:

- a minimum of 12 hours of training **per year** as required in § 44:74:02:02(4), and
- a minimum of 12 hours of employment as a nurse aide for monetary compensation during the preceding 24 months.
  - Contact diana.weiland@state.sd.us for questions on in-service training requirements.

An incomplete form will result in denial of registration renewal.

Name: First_____ Middle_____ Last _____

Other names previously used:_____

Registry #:_____

Mailing Address:_____ City_____ State_____ Zip_____

Telephone: Home: ( ) _____ Cell: ( ) _____ Other: ( ) _____

Email: _____ **Date of Birth**:_____

Social Security #: _____ **Gender**: ❑Male ❑Female

Ethnicity: ❑Caucasian ❑Black ❑Hispanic ❑Asian/Pacific Islander ❑American Indian/Alaskan Native ❑Other

Disciplinary Information:

Please provide details and/or documentation to explain each question with a "yes" answer. You may attach additional pages to the application if needed. If further information is required, you will be notified by the Board.

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations that have not previously been reported to the Department of Health?	□ Yes	□ No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	□ Yes	□ No
3.	Have you ever had an allegation against you for abuse, neglect, or misappropriation of property?	□ Yes	□ No
4.	Are you currently being investigated or is disciplinary action pending against any license(s) or certificate(s) held by you?	□ Yes	□ No
5.	Has any license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	□ Yes	□ No
6.	Have you ever had privileges revoked, reduced, or otherwise restricted at any healthcare provider entity?	□ Yes	□ No
7.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	□ Yes	□ No
8.	Do you currently owe child support arrearages in the amount of $1000 or more?	□ Yes	□ No
9.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance since your last renewal?	□ Yes	□ No
10.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	□ Yes	□ No
11.	Have you ever had action taken against you by the Office of Inspector General (OIG)?	□ Yes	□ No

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This Section To Be Completed By Nurse Aide Applicant

☐ YES ☐ NO I have been employed for monetary compensation as a nurse aide during the preceding 24 months for at least 12 hours.

☐ YES ☐ NO I have completed a minimum of 12 hours of training **per year** (24 hours total) within the last 24 months.

☐ YES ☐ NO Do you have a record of abuse, neglect, misappropriation, or is there any pending action?

I declare and affirm that, to the best of my knowledge and belief,
all of the information provided on this application is complete, true, and correct.

CNA Signature: _____ **Date:** _____

Employment Verification – This Section To Be Completed By Employer

Dates of Employment: **From:** _____ **To** _____ (If presently employed, use "present")

Total number of hours worked during this period: _____

☐ YES ☐ NO This applicant has completed a minimum of 12 hours of training per year within the last 24 months (24 hours total)

☐ YES ☐ NO Does this applicant have a record of abuse, neglect, or misappropriation, or is there any pending action?

☐ YES ☐ NO I affirm that, to the best of my knowledge, all information provided on this Verification is complete, true, and correct.

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Employer: _____

Address: _____

City, ST, Zip: _____

Telephone: _____ **Date:** _____

Employer Representative Signature/Title: _____

Send this completed application to the fax number listed above or email to Ashley.Kroger@state.sd.us

Updated 02/2017